CAPITAL FAMILY ORTHODONTICS

PATIENT INFORMATION

Patient Name:
last first middle

Date of Birth:_____ Gender: ☐Male ☐Female

Dentist Name & Office Phone Number: _____

Who can we thank for referring you? _____

Responsible Party #1:
last first middle

Address:
Street City State Zip

Phone: (C)_____ (W)_____ Occupation:

E-mail:_____ Employer:

Social Security #: ___-___-___ Birthdate: __/__/__ Relation to Patient:

Responsible Party #2:
last first middle

Address:
Street City State Zip

Phone: (C)_____ (W)_____ Occupation:

E-mail:_____ Employer:

Social Security #: ___-___-___ Birthdate: __/__/__ Relation to Patient:

INSURANCE INFORMATION

Insured's Name: _____ Relationship:

Insurance Co. Name: _____ Phone#

Member ID#: _____ Group#:

_____

HEALTH HISTORY

CAPITAL FAMILY ORTHODONTICS

Has the patient been consulted previously by an orthodontist? Yes ☐ No ☐
Is the patient having jaw pain or discomfort at this time? Yes ☐ No ☐
Does the patient feel nervous about having ortho treatment? Yes ☐ No ☐
Is the patient taking any medications, drugs or pills? Yes ☐ No ☐
If yes, reason:

Is the patient aware of any allergies or have they ever reacted adversely to any medication or substances (Such as latex or any metals)? Yes ☐ No ☐
If yes, please list:
Does the patient require medication prior to dental procedures? Yes ☐ No ☐
If yes, please list:
What are the patient's or parent's primary concerns regarding his or her smile?

_____

Indicate which of the following the patient has had or has present. Circle Yes or No

Adenoids Removed	Yes ☐	No ☐	Cosmetic Surgery	Yes ☐	No ☐	Liver Problems	Yes ☐	No ☐
AIDS/HIV	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Kidney Problems	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐	Mental Health Issue	Yes ☐	No ☐
Anorexia/Bulimia	Yes ☐	No ☐	Endocrine Disorders	Yes ☐	No ☐	Mononucleosis	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐	Nervousness	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Fainting or Dizziness	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐
ADD	Yes ☐	No ☐	Hearing Loss	Yes ☐	No ☐	Pregnant	Yes ☐	No ☐
Birth Defect	Yes ☐	No ☐	Heart Pacemaker/	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Hereditary Problems	Yes ☐	No ☐	Surgery	Yes ☐	No ☐	Rheumatism	Yes ☐	No ☐
Blood Transfusion	Yes ☐	No ☐	Heart Trouble	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐
Bruise Easily	Yes ☐	No ☐	Hemophilla	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Hepatitis A	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐
Cold Sores	Yes ☐	No ☐	Hepatitis B	Yes ☐	No ☐	Skin Disorder	Yes ☐	No ☐
Cortisone Medicine	Yes ☐	No ☐	Immune Disorder	Yes ☐	No ☐	Stroke	Yes ☐	No ☐

Additional comments or any other information that you can share that will aid us in treating the patient?

Is the patient on a special diet? Yes ☐ No ☐
If yes, what?
Does the patient have any disease, condition or problem not listed? Yes ☐ No ☐
If yes, what?
Have there been any injuries to the face, mouth, or teeth Yes ☐ No ☐
If yes, what?
Has the patient ever sucked a thumb or finger? Yes ☐ No ☐
If yes, are they still?
Does the patient have any speech problems? Yes ☐ No ☐
If yes, what?
Is the patient a mouth breather? While awake? Yes ☐ No ☐ While asleep? Yes ☐ No ☐
Has the patient ever been informed of any missing or extra permanent teeth? Yes ☐ No ☐
If yes, which ones?

I have read and understand the proceeding questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT:

The undersigned hereby authorizes Capital Family Orthodontics to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of the patient's dental needs. I also authorize Capital Family Orthodontics to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that CFO choose to employ such assistance as deemed fit.

Parent Signature: _____ Date:

_____

CAPITAL FAMILY
ORTHODONTICS

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to your family. Please review our office's financial policy and acknowledge your understanding of this document with your signature at the bottom of the page. If you have any questions, please discuss them with our billing staff or office manager.

Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we accept cash, check, Visa, MasterCard, American Express & Discover.

- **Your insurance coverage is a contract between you and your insurance company.** As a courtesy, upon verification of coverage, we will file an insurance claim for orthodontic treatment on your behalf. If your insurance company does not pay the practice within a reasonable period, we will look to the subscriber of the plan for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

  - *If orthodontic treatment is still being rendered but your insurance has terminated, you are responsible for paying the remainder which was not satisfied by your plan. If your insurance has terminated because of new employment or a change in coverage, we request that you provide the practice with new insurance details within **thirty days** of the change in order to avoid financial complications with treatment.*

In the case of a divorce, regardless of decree, **the parent who brings the child to his/her appointment is responsible to pay** for the child's services. Reimbursement must be made between the divorced parties. **We will not intervene.**

Our office is committed to making orthodontic care easy and affordable for all our patient families. We offer an in-house, zero interest payment plan with varying down payment options based on the type of treatment. We also partner with Sunbit, a third-party financial institution that has up to an 85% approval rate.

APPOINTMENT CANCELLATION POLICY – We kindly request that you provide us with **24-HOUR NOTICE** should you need to reschedule an appointment. Appointments that are missed or rescheduled LESS THAN THE 24 HOUR required notice will be charged a Cancellation Fee:
*Cancellation of a routine Orthodontic Appointment such as an adjustment or bonding is $25 per child, per visit.

*Cancellation of an Orthodontic Appointment such as application of braces or scanning for Invisalign will result in the requirement to **satisfy the down payment** listed on your orthodontic treatment proposal.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature **Date**

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ORTHODONTICS

Understanding Orthodontic Insurance

Orthodontic insurance is vastly different from dental insurance benefits. Your orthodontic coverage is not based on what you need or what your orthodontist recommends. It is based on how much your employer pays into the plan. When deciding on starting orthodontic treatment, your plan benefits should not be the only thing you consider—the best treatment plan for your overall dental health should be determined by you and your orthodontist.

General Orthodontic Benefit Information:

- Orthodontic insurance is often viewed as a lifetime benefit. Once you use any or all the benefit on your plan, it will not replenish yearly as dental benefits do.
- Orthodontic benefits are paid over the duration of treatment, not in one lump sum. Since orthodontic treatment is carried out over the course of several months, insurance companies will pay on a monthly, quarterly, or yearly basis.
- Orthodontic benefits are determined one of two ways; either it is covered at a percentage, or the treatment fee will meet the lifetime maximum.
- Your plan may require a waiting period to be satisfied before any orthodontic benefits will be considered.
- Dependent on the coverage, there may be an age limit that applies to family members listed on the plan. The age limit can range from 16-26 years old.
- Your plan may require a deductible to be paid toward orthodontic treatment before coverage is considered.
- Some plans are required to pay the subscriber directly for orthodontic benefits instead of paying to the provider.

Preferred Providers:

- The plan may want you to choose dental care from its network of preferred providers. This term means that certain dentists have a contract with that specific dental plan; it does not mean that these are orthodontists that patients prefer. If you receive orthodontic care from a doctor who is not in the network, you may have higher out of pocket costs.

Dual Insurance Plans:

- Coordination of benefits is a term that is used when deciphering who is the primary and secondary insurance holder. Even though you may have two or more dental/orthodontic plans, there is no guarantee that your plans will pay for all of the services leaving you with little to no out of pocket cost. Each insurance company handles COB in its own way, so please refer to your plan details for further clarification.

I acknowledge that I have been made aware of the general innerworkings of orthodontic insurance. I also understand and agree that the terms may be amended from time to time either by the practice and/or by the insurance companies in which Capital Family Orthodontics may bill to.

_____ _____

Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, , have been informed of and understand the office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only:

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (please specify)

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